DR. PAUL W. STRATTON

STRATTON FAMILY CHIROPRACTIC WELLNESS CENTER

"OUR FOCUS IS YOUR QUALITY OF LIFE."

PRACTICE MEMBER INFORMATION

Name: ______________________________ Date: ______________

Address: Street: ______________________________ Apt. No.: __________

City: ____________________ State: ________ Zip: ______________

Phone: CIRCLE which to call first to contact you: Home - Cell - Work

Home: ________________ Cell: ________________ Work: ________________

Email: ____

Date of Birth: ___________________________ Age: ___________

Occupation: ____

Employer: ____

Who do we thank for referring you to our office?: __________________________

Marital Status: S __ M __ D __ W __ Other __ Name of Partner/Spouse: _________

Number of Children & Their Age(s): ______________________________________

Have you had previous chiropractic care? ______________

If yes, when: ____

What was your impression of that experience?: ______________________

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SPINAL HISTORY

There are many activities that effect our spine throughout our life. Physical, Chemical and Emotional "traumas" can effect the bones (vertebra) of the spine. These trauma can create a potential for spinal injuries that create interference to our spinal nerves. This is a condition known as a vertebral subluxation. Many times the first trauma to your spine that results in interference to your nervous system (the first vertebral subluxation) is a result of the birthing process. In addition, an estimated 50% of infants fall on their head or are dropped (over 1 million each year). Children are very active and experience many traumas to their spine. This results in the possibility of interference to your nervous system as it can result in a vertebral subluxation. Please answer the following questions about your childhood to assist us in determining your spinal health.

A. Birth Process:

	Yes	No	Comments	Chiropractor's Comments
Born in a hospital:				
Mother given drugs:				
Long Labor:				
Difficult Delivery:				
Delivery Induced:				
Forceps Used:				
Cesarean Birth:				
Breach / Cephalic:				

B. Childhood Growth & Development:

	Yes	No	Comments	Chiropractor's Comments
Did you fall out of bed:				
Falls learning to walk:				
Any falls down steps:				
Fall off bikes:				
Falls from trees:				
Other falls:				
Sports injuries:				
Childhood Accidents:				
Childhood Surgery:				
Childhood Medications:				

C. Current Health Habits:

The human body is designed to be healthy. In order to experience overall health, a balance within all life areas are essential. Throughout life, events may occur which damage your health expression. This section is designed to evaluate the current status of your nerve system.

	Yes	No	Comments	Chiropractor's Comments
Did/Do you smoke:				
Did/Do you drink alcohol:				
Any Accidents:				
Any Surgeries:				
Exercise Regularly:				
Sleeping Dysfunctions:				
Do you eat nutritionally:				
Nutritional supplements:				
Physical Stress:				
Mental Stress:				

Rate your Stress Levels: On a scale of 1 to 10 (10 being the highest): ____________

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OVERALL HEALTH HISTORY

* Reason for today's visit (please check one):
Wellness Care/Maintenance: _____ Spinal Evaluation: _____ Acute/Intensive Care: _____

* If you came in for acute/intensive care, please answer questions 1 thru 5 below:

1. Nature of your condition: ____________________
2. When did you first notice this condition? _______ Is this a reoccurring condition?: _______
3. What aggravates your condition? ____________________
4. Since this condition began, what have you tried that has not fully worked?
   (i.e. - ice, heat, massage, medication, etc.): ____________________
5. Does it interfere with:
   Sleep: Yes ____ No ____ Work: Yes ____ No ____ Exercise: Yes ____ No ____
6. Is this condition the result of:
   An Auto Accident: Yes ____ No _____ * If yes, give date of accident: ____________
   Work related: Yes ____ No _____ * If yes, give date of accident: ____________
   Other type accident: Yes ____ No _____ * If yes, give date of accident: ____________

* Have you been seen for any health condition (including the reason you have come to our office today) by a doctor other than a chiropractor in the last 12 months?
Yes _______ No _________
If yes, please explain: ____________________
____

* Drugs you are currently taking: List Prescription / Over-the-Counter / Non-Prescription:

Medication	How Much	How Long	Purpose for taking

* Rate your commitment to be truly healthy:

On a scale of 1 to 10 (10 being the highest): ___________

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NOTICE OF PRIVACY PRACTICES

We care about our Practice Members privacy and strive to protect the confidentiality of your health information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your health information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact our office.

Who will follow this notice:
Any health care professional authorized to enter information into your chiropractic record, all employees and staff who may need access to your information must abide by this Notice.

How we may use and disclose health information about you:

* **For treatment:** We may use health information about you to provide chiropractic care or services.
* **For payment:** We may use and disclose health information about you so that the care you receive from us may be billed and payment may be collected.
* **For Health Care Operations:** We may use and disclose medical information about you for health Care operations to assure that you receive quality care.

Other Uses or Disclosures that can be made without your consent or authorization:

* As required during an investigation by law enforcement agencies.
* To avert a serious threat to public health or safety.
* As required by military command authorities for their medical records.
* In response to a legal proceeding.
* To a coroner or medical examiner for identification of a body.
* If an inmate, to the correctional institution or law enforcement official.
* As required by the US Food and Drug Administration (FDA).
* Uses and disclosures required by law.
* Uses and disclosures in domestic violence or neglect situations.
* Health oversight activities.
* Other public health activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring your written authorization:
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. You may revoke that authorization in writing, at any time.

I, ______________________________ have read and fully understand the above statements.
(Print Name)

____ ______________________

(Signature) **(Date)**

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TERMS OF ACCEPTANCE

When a client seeks chiropractic health care and we accept a client for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each client understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read & fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

________________________________ ____________________
(Signature) (Date)

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FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to assisting you in obtaining your optimal results with your health.

Forms of Payment:
Practice members are responsible for full payment at the time of service. We accept cash, personal checks, debit and credit cards (VS, MC, & AX). Any credit arrangements must be authorized in advance. We do not accept Discover Cards.

Insurance/Contract Services/Third Party:
All professional services are rendered and charged to the practice member receiving care and not to an insurance provider. We will supply you with receipts and assistance with paperwork to help you receive reimbursement from any involved third party. We are not a participating (in network) provider for any managed care programs. Additionally, we will not pre-certify or verify "medical" necessity for chiropractic care with any third party programs. We will not become involved in disputes with your insurance company or attorney regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc., other than to supply factual information. We do not guarantee reimbursement to you from your insurance carrier.

Practice Member Agreement:
I have read, understood, and agree to this Financial Agreement.

______________________________ (Signature)

____________________ (Date)